

Samaritan Community Center - Dental Clinic Patient Information Form

Patient Name: _____

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Prefer not to disclose

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Message Phone: _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Race/Ethnicity: ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Hispanic/Latino

Insurance Information (Please provide Driver's License and Insurance Card)

Medicare: ☐ Yes ☐ No Medicare Part C: ☐ Yes ☐ No

Dental Insurance: ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No

Medicaid Dental: ☐ Yes ☐ No

Employment Information Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Other

Employer Name (if employed): _____

Employment Type: ☐ Full-Time ☐ Part-Time ☐ Temporary

Veteran Status: ☐ Yes ☐ No

Housing: ☐ Own/Rent ☐ Transitional Living (Facility): _____ ☐ Other _____

Emergency Contact Name: _____ Phone: _____

Household Members: _____ Adults: _____ Children: _____ Monthly Income: \$ _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Dental Questionnaire/ Medical History

Patient's Name: _____ Date of Birth: _____ Today's date: _____

Medical Doctor's Name: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Any pre-medication/antibiotic required: [Yes/No] Reason: _____

How long has it been since you have been to the dentist: 0-2 years _____ 3-5 years, _____ 5-10 years _____ 10 plus _____

Have you ever had a bad dental experience Yes / No

If yes, please explain _____

Do you use Tobacco products? Yes/ No. If yes what form, _____, how much, _____ and how long?

Do you use recreational drugs such as Marijuana or Methamphetamine? _____ We do not report, please advise the staff if you have used recreational drugs within 24 hours of your dental appt.

Known Allergies: Or Medication unable to take- Please mark all that apply () None known () Ibuprofen, () Acetaminophen () Amoxicillin, () Cephalaxin, () Azithromycin, () Clindamycin, () Metronidazole, () Augmentin, () Penicillin, Other _____
() Any Metal(s) () Silver () Aspirin () Codeine () Hydrocodone () Iodine () Latex () Local Anesthetic, () Sulfa

For women only: Are you pregnant? Y/N, Breastfeeding? Y/N, Taking birth control pills? Y/N

Medical conditions: Please check if you currently have/or have been diagnosed in the past with any of the following.

IF NONE PLEASE INITIAL HERE AND DATE: _____

- ☐ AIDS/HIV
- ☐ Allergies Seasonal
- ☐ Alpha-Gal (Meat Allergy)
- ☐ Anemia
- ☐ Alcohol/ Drug Addiction
- ☐ Anxiety/Depression
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Auto Immune Disorder
- Taking immunosuppressant Yes/No
- ☐ Asthma
- ☐ Bisphosphonate Therapy
(for osteoporosis - IV)
- ☐ Blood Transfusion/Problems
- ☐ Blood Disease
- ☐ Cancer/Type: _____
- ☐ Date Diagnosed: _____
- ☐ Chemotherapy Last Date _____
- ☐ Circulation problems
- ☐ Chronic Pain Problems
- ☐ Congenital Heart Defect

- ☐ Cough, Chronic/Severe
- ☐ Dementia/Alzheimer's
- ☐ Diabetes Type 1 or 2
- ☐ A1C _____ Date _____
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizure
- ☐ Fainting
- ☐ Food Allergies
Type _____
- ☐ Hay Fever Sinus
- ☐ Headaches/Migraines
- ☐ Herpes A-Oral fever blister
- ☐ Heart Attack
Date: _____
- ☐ Heart Surgery:
Date: _____
- ☐ Heart Murmur
- ☐ Heart Problems
Describe _____
- ☐ Hemophilia
- ☐ Hepatitis (A B or C)

- ☐ High Blood Pressure
- ☐ Kidney / Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Neck/Back Problems
- ☐ Nervous Problem
- ☐ Pacemaker Date placed: _____
- ☐ Pain Management
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sexually (Venereal) Transmitted Disease
- ☐ Sleep Apnea
Do you use a Cpap Yes/ No
- ☐ Stroke
Date: _____
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other not listed _____

Samaritan Dental Clinic Patient health questionnaire

Patient Name: _____

Please list Surgeries or Hospitalization and Dates: _____

Current medications, including over the counter. Please list all. Please include an additional page if needed.

Medication Name	Dosage	Frequency	How Long	Condition being treated

Authorization: I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment i receive at this office and may be shared with other medical offices only as necessary. I agree to notify the office if any of the information changes in the future.

Signature of the patient, or guardian: _____

To be completed by staff:

Reviewed by: _____ Date: _____

Date: _____ Please initial No Change _____ Change noted on form _____

Date: _____ Please initial No Change _____ Change noted on form _____

Date: _____ Please initial No Change _____ Change noted on form _____

**To be initiated by the assistant, hygienist or dentist reviewing the health history with the patient. **

Samaritan Dental Clinic

Notice to Patients with Regards to Medical History

Having a complete medical history is a key factor in helping us provide the necessary standard of care. All patients must provide an accurate and up to date medical history for the doctor to review. In the event that there is a medical condition that is complex, we may be unable to perform certain dental procedures, as certain conditions fall outside the scope of services we are able to provide. If this is the case, information on other possible medical resources in the area will be provided.

Your signature acknowledges your receipt and understanding of this requirement.

Patient Signature _____

Date _____

Authorization to Release Personal Protected Health Information to an Individual

Patient Full Name: _____

Patient Date of Birth: _____

- ☐ **I do not authorize** the release of any dental information to any individual except for treatment and health care operations as specified in Samaritan Dental Clinic's Notice of Privacy Practices.
- ☐ **I hereby authorize** the release and disclosure of my dental information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: records of all visits, records of visits for any and all dates, copies of records or reports provided to specialists, progress notes and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected dental information.)

Name	Relationship to patient

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist.
4. This authorization will expire 1 year from the date of the signature.
5. Samaritan Dental Clinic, its employees, officers, and dentist are hereby released from any legal responsibility or liability for disclosure of the above information to the extent of indicated and authorized herein.
6. Treatment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
7. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Patient's Printed Name

Patient's Signature



Required Notice to Persons Receiving Health Care Services at Registered Free or Low-Cost Healthcare Clinics

This clinic is registered with the Arkansas State Board of Health as a Free or Low-Cost Healthcare Clinic. Pursuant to Arkansas law, any health care professional that renders volunteer health care services at this location, shall not be held liable for any civil damages, for any act or omission resulting from the rendering of the health care services unless the act or omission was the result of the health care professional's gross negligence or willful misconduct.

By my signature below, I acknowledge that any health care professional(s) providing volunteer health care services to me (or my dependents) are not liable for civil damages, as provided under Arkansas law.

Furthermore, I acknowledge that the Arkansas Board of Health and its members, the Arkansas Department of Health and its agents and employees are exempt and immune from liability for any claims or damages when performing their duties under this section.

Patient Name: _____ Date: _____

Samaritan

COMMUNITY CENTER

P.O. Box 939 Rogers, AR 72757 Phone - 479-636-4198

Release Form for Media Recording

I, the undersigned, do hereby consent and agree that Samaritan Community Center/Samaritan Shop have the right to take photographs, videotape, or digital recordings of _____ and to use these in any and all media, now or hereafter. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to Samaritan Community Center/Samaritan Shop all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that Samaritan Community Center is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement. If under the age of 18 a parent or guardian must sign.

Patient Accepts Media Release:

Patient Signature : _____ Date: _____

Patient Declines Media Release :

Signature: _____ Date _____

Acknowledgement of Receipt of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Samaritan Dental Clinic Notice of Privacy Practices.

Patient Signature _____ Date _____

STAFF USE ONLY

We provided the Notice of Privacy Practices to the individual above /patient. Written acknowledgement could not be obtained because:

- ☐ An Emergency prevented us from obtaining acknowledgement
- ☐ A Communication barrier prevented us from obtaining acknowledgement
- ☐ Patient or representative declined to sign the Acknowledgement of Receipt
- ☐ Other (please specify) _____

Printed Name of SDC Staff Member or Volunteer _____

Signature of SDC Staff Member or Volunteer _____ Date _____

Pre-Treatment Assessment

Patient Information:

Name: _____

Date: _____

1. Pain Assessment:

On a scale from 1-10 (1 = no pain, 10 = worst pain imaginable), how would you rate your dental pain today?
(Circle one: 1 2 3 4 5 6 7 8 9 10)

2. Functional Limitations:

- Do you have trouble eating due to dental pain? (Yes / No)
- Do you have trouble speaking due to dental pain? (Yes / No)
- Has your dental condition affected your sleep? (Yes / No)

3. Oral Health Knowledge & Awareness:

- How often should you brush your teeth?
 - a) Twice a day
 - b) Once a day
 - c) Once a week
- How often should you floss?
 - a) Daily
 - b) A few times per week
 - c) Never
- How often should you visit the dentist?
 - a) Every 6 months
 - b) Once a year
 - c) Only when I have a problem
- How confident do you feel about taking care of your teeth after a dental procedure?
 - a) Very Confident
 - b) Somewhat Confident
 - c) Not Confident

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided on behalf of the Samaritan Health Clinic.

PURPOSE: This Notice of Privacy Practices describes how we may use your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health, and may include name, address, phone numbers, and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained by sending a written request to the Samaritan Health Clinic, HIPAA Officer, 1211 West Hudson Road, Rogers, AR 72756.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your Privacy Rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the clinic HIPAA Office, Samaritan Health Clinic, 1211 West Hudson Road, Rogers, AR 72756. There will be no retaliation for filing a complaint.

If you have questions or need more information, contact the clinic HIPAA Officer at (479) 636-4198.

WHO WILL FOLLOW THIS NOTICE: The Notice describes the practices of the Samaritan Health Clinic healthcare professionals, employees, volunteers and others who work or provide healthcare services.

ACKNOWLEDGEMENT: You will be asked to sign an Acknowledgement of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgement.

Your Privacy Rights. You have the following rights relating to your Protected Health Information and may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records. Your request to obtain a copy of your medical records must be in writing. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by the Samaritan Health Clinic who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to these restrictions in all circumstances.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- We will obtain your written permissions for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the Medical Records Department.

Our Responsibilities. We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, make the Notice available to you and to notify you if we are unable to agree to a requested restriction or an alternative means of communicating.

Examples of Uses and Disclosures

We will use your Protected Health Information for treatment. Certain information obtained by a nurse, doctor, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care.

We will use your Protected Health Information for payment. A bill may be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used.

We will use your Protected Health Information for regular healthcare operations. The Medical Staff and other healthcare workers may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the clinic.

Business Associates: We may share some of your Protected Health Information with outside people of companies who provide services for us, such as typing physician reports.

Notification: We may use or disclose your Protected Health Information to notify a family member or other person involved in your care, your location and general condition unless you tell us not to do so.

Communication with Family: We may share your Protected Health Information with a family member, a close personal friend, or a person you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

Research: Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

Coroners, Medical Examiners, Funeral Directors: We may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out their duties.

Organ Donor Organizations: We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

Contacts: We may contact you to provide appointment reminders or to tell you about new treatments or services.

Fundraising and Marketing: We may contact you as a part of any fundraising or marketing effort.

Food and Drug Administration (FDA): We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

Workers Compensation: We may disclose your Protected Health Information for workers' compensation claims.

Public Health: We may give your Public Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose your Protected Health Information needed for your health or the health and safety of others.

Law Enforcement: We may disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law.

Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

Abuse or Neglect: We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.

Legal Proceedings: We may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.

Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety of the health or safety of the public or another person.

For Specific Government Functions: In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activities as required by law.